Creating Health
Could an Asset Approach Improve Health and Wellbeing Across the Hywel Dda Area?

A Report for Hywel Dda Public Health Team

Jan Batty, West Wales Action for Mental Health

April 2014
About this Report

The Director of Public Health for Hywel Dda University Health Board commissioned this report from West Wales Action for Mental Health who appointed me to research and write it. The views expressed in this report are mine and do not necessarily reflect those of the Hywel Dda Public Health Team or West Wales Action for Mental Health.

I wish to thank the people who donated their time to talk to me about their work and point me to helpful sources of information. Any errors or glaring omissions are my responsibility alone.

In researching and writing this report I am aware that I have only scratched the surface of a large and potentially rich seam of knowledge. By writing it from a personal perspective I hope that my own reflections will engage the reader more actively in the report. Hopefully others will be inspired to find out more and to have the courage to bring assets approaches to their work and relationships. See the ‘Further Reading’ section if you are interested in finding out more.

Jan Batty, West Wales Action for Mental Health
April 2014

Jan Batty
c/o Hywel Dda Public Health Team
Tregaron Hospital
Tregaron SY25 6JP

jan.batty@wales.nhs.uk
Tel. 01970 613907

West Wales Action for Mental Health
The Mount
18 Queen Street
Carmarthen SA31 1JT

director@wwamh.org.uk
Tel. 01267 238367
Creating Health: could an asset approach improve health and wellbeing across the Hywel Dda area?

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Key Messages

‘Health assets’ are any factor that supports individuals, communities and populations to maintain and sustain their health and wellbeing. The asset approach is a way of working that recognises and values the capacity, skills, knowledge, connections and potential in a community. Asset approaches are place-based, relationship-based, citizen-led and promote social justice and equality.

The tools and techniques for a health assets approach include Asset Mapping, Appreciative Inquiry, Asset Based Community Development, Participatory Appraisal, Open Space Technology. Co-production is the application of an assets approach to services.

The more familiar deficit approach looks for problems and needs and aims to design services to meet them. In doing this it may inadvertently produce disempowered and disengaged consumers of services rather than active citizens.

There is good research evidence for the positive impact of individual and community assets such as resilience, self determination, reciprocity, social networks and community engagement on health and wellbeing.

The assets approach does not replace investment in traditional health promotion, improving services, addressing the socio-economic determinants of health or tackling the structural causes of health inequality. Instead the aim is to redress the balance towards work that promotes wellness rather than a focus on deficits and avoiding risk and illness.

Work on health assets is not without its challenges. It potentially requires a change in attitude and values by everyone involved, may have unpredictable outcomes and takes time. It may need up-front investment to give professionals the skills they need.

Adopting asset thinking in public health would require a paradigm shift away from the current concept of health defined in negative terms. Asset approaches have the potential to broaden health improvement work to include supporting communities and building on their assets.

We need to employ new methods for evaluating health assets approaches to better understand the impact of assets and protective factors. These are likely to be qualitative and participatory research methods. We should look to adopt new asset indicators which reflect the whole health of the population.

There are opportunities for Hywel Dda Public Health Team to use the principles of asset approaches to plan new initiatives, consider the practical application of health assets mapping; adopt new methods of evaluation; take assets thinking into Population Health Groups; and influence others to apply assets approaches in their work.

The assets approach provides a set of values and principles which can be used as a framework for organisations in health and social care in the Hywel Dda area to reorient services or to identify and build on current work.
1. Introduction

The Assets Approach to Health and Wellbeing

‘We can’t do well serving communities… if we believe that we, the givers, are the only ones that are half-full, and that everybody we’re serving is half-empty… there are assets and gifts out there in communities, and our job as good servants and as good leaders… [is] having the ability to recognise those gifts in others, and help them put those gifts into action.”

First Lady Michelle Obama, 2009

Interest in asset approaches to health and wellbeing has grown significantly over the past few years. Whilst not an entirely new idea there may be pressing reasons why this different way of working has come to such prominence right now. It has been suggested that focusing on assets can address stubborn and widening health inequalities, transform public services and revitalise public health.

An asset based approach values the capacity, skills, knowledge, connections and potential within an individual or community. As a way of thinking it complements the common focus on problems and needs which we call a ‘deficit model’. Instead of looking at the gaps where services need to be provided an assets approach views the ‘assets’ that already exist as resources to be used and looks to what is working, seeking to build on that.

In 2011 the Welsh Assembly included this statement in a report about the wellbeing of children and young people:

‘While this deficits model is important, it should ideally be complemented by addressing assets; those factors that develop resilience and promote positive health and wellbeing, such as participating in leisure activities, enjoying a positive school environment and ease of communication with family and friends.’

More recently the Welsh Health Minister and the Chief Medical Officer for Wales have spoken positively about the possibilities of assets based approaches to health and wellbeing. A Co-production Implementation Group has been set up by the Welsh Government. This is an approach which is gaining supporters at a high level and which is being tested locally in Wales, Scotland, parts of England (especially the North), and internationally.

The Director of Public Health for Hywel Dda University Health Board commissioned this report. It explores what is meant by health assets and asset based approaches, the evidence we have for their effectiveness, and by looking at examples, makes some assessment of the potential usefulness of asset approaches to improve the health and wellbeing of the local population.

Language and Methodology

In a fast-developing area where people are learning about new ideas it is critical that we have a shared understanding of the words we are using. In this report I use a definition of health as ‘a resource for everyday life’ or the ‘foundations for achievement’. In the
glossary I have set out the generally accepted meanings of the most used terms (which appear in italics), but where individual organisations or communities are taking on an asset-based approach, defining their own preferred terms may be a first step to taking ownership of the work.

There are many examples of places where an assets approach is being used. In this report I have chosen ones that seem particularly relevant to our work in health and which illustrate a particular aspect of these approaches. For a full description of the methodology for this report, see Appendix 1.

Why now? – Some background

In public health we are slowly understanding that many of the modern, seemingly intractable ‘problems’ such as ‘obesity’ and inequalities in health, are complex and have overlapping aetiologies. They do not have a simple cause-effect relationship and it is possible that they can’t be solved by single topic interventions in a linear way. Could a different way of thinking open up opportunities for a more effective way of working? Health inequities are increasing. For some this indicates that what we are doing is not working7. For others it simply means we haven’t done enough of what works – the redistribution of wealth and creating a more equal income society8-9. Shrinking budgets mean public services simply cannot provide what they used to in the same way. ‘Doing less with more’ has become a societal mantra.

Cynics may say that a decreasing spending pot is encouraging public bodies to shift the responsibility for local services and for health and wellbeing onto individuals and communities – The ‘Big Society’ - so that they can withdraw from services. There may be some truth in this. However, in every crisis there is an opportunity. Constraints force people to think creatively. I will suggest that the ethos of an assets approach is valid as long as the intention is to place more power with communities and individuals, rather than just a focus on individual responsibility without state support. The opportunity here is for people and communities to take back some control of their lives. And, as we shall see, that in itself can have a positive impact on health and wellbeing. As this is something that public services say they want, then it should be a win-win situation, though not without its challenges.

2. What do we mean by Health Assets and Asset Approaches?

“We do not describe the world we see, we see the world we describe.”
Joseph Jawroski

Health Assets

“A health asset is any factor or resource which enhances the ability of individuals, communities and populations to maintain and sustain wellbeing. These assets can operate at the level of the individual, family or community as protective or promoting factors against life’s stresses.”10
In the health promotion community health is defined as a positive concept, a ‘resource for everyday life’ rather than an end in itself. Closely linked to the idea of health assets is the theory of Salutogenesis – the origins of health. Anton Antonovsky, who developed the theory, became interested in why some people stay well in situations of adversity, and others don’t. He countered the dominant approach to understanding health in terms of disease and deficit with one which aims to describe how health and wellbeing is created and supported in a person.

Antonovsky identifies two sets of parameters that contribute to the health of an individual. One set he calls ‘Sense of Coherence’ (SOC) which reflects a person’s view of life and their capacity to respond to stressful situations. The other he calls ‘Generalised Resistance Resources’. These are all the resources within people and outside them that help someone to cope – for example money, social support, faith or ego strength. Together they help people adapt to adversity. Individuals look for inputs from the social and physical environment, as well as their personal resources, in order to cope with difficult experiences.

This more complete view of health has been modelled by Barton and Grant (building on Dahlgren and Whitehead’s original). It shows an individual at the centre of a web of interlinking systems that impact on their health – the ‘wider determinants’ – and which they can also influence.

The implication of this model is that actions to improve health need not focus on individual behaviour alone, but can be targeted at other societal, economic and environmental systems to improve health outcomes.
Deficit Thinking

Our ideas about society and public services in particular are so ingrained that, like fish in water, we no longer realise we are surrounded by them. Deficit thinking is one such idea that has permeated public policy for decades. We see problems and needs and design services to address them and to fill the perceived gaps. In public health we have overwhelmingly looked at the risks to health and patterns of disease rather than investigate patterns of health and what creates wellness (mental health promotion being a notable recent exception).

The problem with services that set out to fix problems is that they may also take away control. Some commentators have criticised the deficit approach by pointing out that it creates a transactional relationship where people feel disengaged and disempowered, passive consumers of services provided by professionals and which result in less than ideal outcomes. And over time this deficit model has, according to some created dependency. But surely the truth is that we all dependent – rich and poor – on a functioning society, a global economic system and finally on each other.

Proponents of an asset approach acknowledge that the deficit model is valid and important, but suggest that there may be great potential in taking a complementary assets approach alongside this. To encourage a different way of thinking about something the expression ‘Is the glass half empty or half full?’ is sometimes used. The question also acts as a psychological tool to distinguish pessimists from optimists. But, the assets approach is more than positive thinking. It is about recognising and valuing the undiscovered or unappreciated assets of individuals and also communities. I would suggest it is crucial also to have an accurate perception of reality in this debate.

Needs do not vanish when we look at assets, but perhaps a rebalancing of the two sides would give a better-rounded picture. For this reason my own chosen metaphor is that of Rubin’s vase – an optical illusion in which it is possible to see either two faces in profile looking at each other or a vase, but not both simultaneously. Usually it takes an effort for us to see one or the other.

Health assets approaches – ways of working which promote and strengthen health assets - build on the experience of disability rights and the anti-psychiatry movements in particular. People with experience of recovery work in mental health, in community development and in progressive third sector organisations will find much in the values of asset approaches that they recognise. Asset based approaches have a set of principles and values that organisations may find a useful framework to apply to their work.

The Assets Approach

At an individual level a health assets approach asks “How can this person be helped towards greater health?” It asks “What can you do?” rather than “What’s wrong?” Similar questions can be asked of larger systems.
The Deficit Approach | An Asset Based way of thinking
---|---
Starts with deficiencies and needs in a community | Starts with assets/resources in a community
Responds to problems | Identifies opportunities and strengths
Provides services to users | Invests in people as active participants
Emphasis on the role of services | Emphasises the role of civil society
Focus on individuals | Focus on communities/neighbourhood and the common good
Sees people as clients and consumers receiving services | Sees people as participants and co-producers with something to contribute
Treats people as passive and ‘done-to’ | Helps people take control of their lives
Fixes people | Supports people to develop their potential
Implements programmes as the answer | Sees people as the answer

(From Assets in Action: illustrating asset based approaches to health improvement, Glasgow Centre for Population Health, 2011)

Proponents of an asset approach argue that asset principles can help us understand what makes us healthy and gives us wellbeing. Foot identifies the following characteristics of an asset approach:

- Asset-based – values assets and associations
- Place-based – works in the neighbourhood as the space in which networks come together and shared interests are negotiated and acted on
- Relationship-based – creates the conditions for reciprocity, mutuality and solidarity
- Citizen-led, community-driven – empowers individuals and communities to take control of their lives
- Social justice and equality – enables everyone to have access to the assets they need to flourish; equality and fairness are both determinants of wellbeing.

These resonate with the principles set out in the Ottawa Charter in 1986 which has been the foundation for health promotion practice since. Taking an assets approach in public health may help us reframe current ‘problems’ to gain a different perspective. In public services co-production relies on an assets approach to transform the relationship between service users and professionals to an equal and reciprocal partnership. Whilst many have advocated for this for years, and services themselves clamour to be patient or client centred, there has been little real progress.

A key point is for us to understand the different responsibilities of each ‘system’. Is this change that that can be led by or involve family, friends and social networks? Or is it best met through cooperation and co-production with services? And which are those that can only be delivered through government or mainstream services?
Even though many of us will recognise the values of the health assets approach, and may even have tried to implement them, perhaps what is different about this new reframing is that it provides a robust set of principles and tools for actually doing it.

3. Tools for an Assets Based Approach to Health and Wellbeing

“If we are to achieve results never before accomplished, we must expect to employ methods never before attempted.”

Francis Bacon

People have developed a number of tools and techniques which are suitable for use with asset working. The first step in the process is generally agreed to be ‘asset mapping’.

Asset Mapping

“Asset mapping is the general process of identifying and providing information about a community’s assets, or the status, condition, behaviour, knowledge, or skills that a person, group, or entity possesses, which serves as a support, resource, or source of strength to one’s self and others in the community.”

Asset mapping is a tool for learning about a community, undertaken by the community, with the support of a skilled community organiser, which focuses on its strengths and resources and which may include those of professionals and policy makers. It is the first step in a process which can lead to other forms of asset based approaches such as social prescribing, time banking or co-production. Health asset mapping is simply a process that reveals those assets that support people’s health.

But asset mapping is more than just gathering data.

“Many projects start by listing all the associations, the public services and the facilities in an area. While this inventory is useful knowledge, it does not achieve the overarching developmental aims of asset mapping, which is to reveal the invisible and overlooked assets held by individuals and associations and to connect them to opportunities like mutual help and coproduction where those assets can improve wellbeing for themselves and for others. It is through the conversations about assets and resources that staff and citizens see how they could work together differently.”

Once community strengths and resources are inventoried and depicted on a tangible map we can more easily think about how to find ways to build on and strengthen those assets for the future. Asset mapping should also generate discussion about ways to improve access to material resources. These could be social and community resources such as credit unions, local shops, community transport, or seeking funding from government or public organisations. One advantage of focusing on assets rather than needs is in getting a common view of the resources of a community. The typical process of focusing on needs
often results in competition by organisations for external resources which can divide communities, whereas asset mapping celebrates uniqueness not homogeneity.

Unfortunately “clear guidelines for mapping assets within a specific health context and at an individual level have yet to be produced”\textsuperscript{18}. However, there are a number of toolkits which lay out the steps for a community asset mapping exercise\textsuperscript{19,20,21}. 

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**WARM (Wellbeing and Resilience Measure)**

WARM is a data analysis method for assessing assets and vulnerabilities in a community developed by the Young Foundation. It provides a framework for starting to measure wellbeing and resilience. It can enable local professionals and communities to see which services are having an impact on people’s lives and which are not; identify a community’s strengths as well as its needs; and make more informed decisions about where to direct limited resources.

WARM can be used to map local assets and vulnerabilities. It can be used to contribute to a general audit or to focus on specific issues such as children and young people.

- **Stage 1:** Measure wellbeing – self, support and structure and systems
- **Stage 2:** Resilience – create a map of assets (e.g. social capital) and vulnerabilities (e.g. isolation)
- **Stage 3:** Benchmarking – compare your data with national data for a region with a similar demographic profile
- **Stage 4:** Planning – inform people about what is working well and where further interventions are needed
- **Stage 5:** Action

*(Taking the Temperature of Local Communities – The Wellbeing and Resilience Measure (WARM), Nina Mguni and Nicola Bacon, Young Foundation, 2010)*

Experience has shown that it is generally more effective to focus on a specific topic or outcome from community consultation or data analysis\textsuperscript{22}. If, for example, there was a concern about isolation in older people then you would start to bring older people together to have conversations about what resources they have between them and what help they need from others. Or by starting with a research question such as ‘what are the health assets in this community?’ asset mapping can be used as a tool to analyse the spread of assets. The qualitative data gathered from stories and experiences can be analysed for common themes related to the original question.

Asset mapping helps us to start to understand what is ‘salutogenic’ – health enhancing – for people in their physical, emotional, economic and cultural environments. By doing this we can begin to identify the most appropriate ‘asset indicators’ to be used in the evaluation of strategies aiming to create the conditions for health\textsuperscript{23}. 

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Appreciative Inquiry (AI)

Appreciative Inquiry is not really a method (though there are a series of recommended steps) but a thought process. It can be used to define outcomes and create a shared vision alongside asset mapping as part of the planning process.

“It is a reciprocal scheme, where people accessing the scheme also contribute their own assets. Social prescribing is not about designing and delivering a specified network of commissioned services for individuals to participate in. It is about identifying, developing and connecting the assets that exist within communities. Once discovered, these capacities can be mobilised”.

(From—‘A Glass Half Full: how an asset approach can improve community health and wellbeing’, Jane Foot and Trevor Hopkins, IDEA 2010)

Case Study – Social Prescribing

Central Lancashire PCT Mental Health Team is using asset mapping to develop ‘social prescribing’ – health workers prescribe social and community solutions such as befriending schemes, volunteering, access to educational or IT skills, support to make use of the library or local sports facilities and so on. They hope this will improve people’s resilience through increasing social connections and sustaining networks that promote self-care and improve health-related behaviours.

“Appreciative Inquiry suggests that we look for what works in an organisation. The tangible result of the Inquiry process is a series of statements that describe where the organisation wants to be, based on the high moments of where they have been. Because the statements are grounded in real experience and history, people know how to repeat their success.”

So instead of asking ‘What problems are you having?’ AI asks ‘What is working around here?’ It can be used, not just with organisations, but almost any group of people.

Appreciative Inquiry has a lovely resonance with salutogenesis. Both seek to discover what is most life-giving in the system we choose to study — the distinctive competencies that sustain its health and vitality. AI is a way of thinking and can be applied to any system where change is desired. It assumes that the nature of the question you ask influences the types of answer you get and that asking only positive questions encourages people to value and build on what is working. AI is a 5 step (or sometimes 4) process for finding out what has been successful in the past around a certain theme, and taking that forward into a shared imagined future. It is important to note that problems are not ignored in AI; instead “Doing more of what works crowds out insoluble problems.”
Asset Based Community Development (ABCD)

“Labels mask people’s gifts. A focus on assets reveals those gifts.”

*Cormac Russell, Faculty Member, ABCD Institute*

Most community development, whilst delivered through participatory techniques, seeks to uncover problems and unmet needs. Interventions to address these problems are then developed and consulted on, often relying on resources from outside the community. Unsurprisingly local people end up viewing their community as a place of problems and deficits which can only be saved with outside help. Asset based community development (ABCD) instead builds on the skills and resources of individuals, the power of voluntary associations of individuals and the assets present in local institutions, physical infrastructure and the local economy. In Asset Based Community Development the process is as follows:

1. Map Assets
2. Build connections
3. Bring community together to develop a vision and a plan

One further difference between conventional community development approaches and an assets based one is a focus on community members as individual agents of change. Starting with the identified assets of an individual, these are matched with people or groups who have an interest or need in that asset. Communities are multi-layered and do not have one voice. IN ABCD it is individuals who form relationships and act to meet needs from within their community and to create associations of common interest. Working with this as a strength, rather than trying to get consensus is a practical necessity. A central assumption of ABCD is that everyone has a gift. With this as a guiding principle ABCD has been successful in including those who have been labelled in some way – with a problem or diagnosis, or as ‘hard to reach’ or simply ‘service user’.

**Participatory Appraisal (PA)**

Participatory Appraisal

Participatory Appraisal embraces a number of approaches aimed at discovering information about the community by local people. Community members are trained to collect and analyse, in as accessible a way as possible, information about their community, including the diversity of views, knowledge and experience. The research question and how it is conducted are decided by a steering group who then collect views through a range of creative and participative methods. These might range from talking to people in the street to going meetings to organising events. The information they collect is then verified by corroborating it with other sources of data.

Although this method has mostly been used to identify needs and priorities in a community, it could be used to collect information about skills, talents and resources in line with the asset model. Once the research is complete it is important to use the same participatory methods in developing any action that comes out of it.
Open Space Technology (OST)

Open Space Technology is a simple way to run productive meetings where the participants decide what is to be discussed. It allows a diverse range of participants to work on a complex issue where nobody knows the answer. It seems to work best if the ‘whole system’ is in the room – a wide range of stakeholders and the key decision-makers. Open Space was invented by Harrison Owen who laid out the following principles:

- Whoever comes are the right people – those who care will get involved.
- Whatever happens is the only thing that could happen, let go of expectations and pay attention to what is happening here and now.
- Whenever it starts is the right time – be creative about how to organise the sessions.
- When it’s over, it’s over – finish when you finish rather than following a set timetable.

In an Open Space session the convenors set a central and open-ended question which is a live issue and which provides a framework for the event. In the context of the question individuals propose a topic for discussion and, through a ‘market-place’, recruit others to join them. The learning from the discussions contributes to answering the original question as well as committing people to future action.

Hackney PCT is using OST events with different population groups to consult on this question: “How can Hackney become a great place to grow old in?” Staff say that the process:

- gets people involved right at the beginning in an open-ended way, rather than starting with the organisation’s agenda
- produces ideas and issues they would never have thought of – for example, isolation is the biggest issue rather than a desire for more services
- gets residents thinking about what their contribution could be to making Hackney better.
- changes the way residents relate to professionals – people are thinking about how they can work together.
- does not create expectations that the PCT can’t meet
- distilled all the different things that had been talked about into a few really important things to do.

(From—‘A Glass Half Full: how an asset approach can improve community health and wellbeing’, Jane Foot and Trevor Hopkins, IDEA 2010)

Story telling

Story telling is an informal and appreciative way of collecting information about people’s experiences of past achievements and successful projects. By sharing stories the value of experience is emphasised, confidence is built and learning can be applied to new problems.
Co-Production

“The meaning of life is to find your gift. The purpose of life is to give it away.”

Pablo Picasso

Co-production is an assets-based approach to the design and delivery of public services. As ‘co-production’ gains ground as an idea it is increasingly important to define what it is and isn’t. As yet there is no agreed definition but the following is a useful description.

“Co-production means delivering public services in an equal and reciprocal relationship between professionals, people using services, their families and their neighbours. Where activities are co-produced in this way, both services and neighbourhoods become far more effective agents of change.”

The term ‘co-production’ was originally coined in the late 1970s by Elinor Ostrom and colleagues at Indiana University to explain why neighbourhood crime rates went up in Chicago when the city’s police officers retreated from the beat into cars. Ostrom noted that by becoming detached from people and their everyday lives on the streets, Chicago’s police force lost an essential source of insider information, making it harder for them to do their work as effectively.

The idea of co-production is quite simple – that in any human relationship a pooling of knowledge and experience creates something more than the sum of its parts. The service user and professionals’ resources or assets are combined to redesign and deliver services.

“Co-production works on the principle that we are all equal partners and all have something of value to contribute. At the heart of the approach are reciprocal relationships, built on trust, respect and mutuality, and on the universal human impulse to give back. There are different levels of co-production: at its most effective it involves a permanent shift in power from service providers to citizens and their communities.”

Some commentators have suggested that it may be useful to approach co-production as a set of distinctive principles rather than trying to define it. The principles of equality, diversity, accessibility and reciprocity have been widely recognised as critical values for putting co-production into action.

Co-production can also be considered as a way of valuing and helping the core economy to flourish (defined by Edgar Cahn founder of time banking the core economy is the underlying operating system that keeps society functioning). In the market system ‘the logic of choice’ turns citizens into consumers – a transactional relationship – whereas the ‘logic of care’ promotes a reciprocal relationship where high levels of trust are built.

It can be helpful to define three levels of co-production:

1. Basic – a description of how all services rely on some input from users. For example, we all co-produce our Council’s waste management system by collecting recycling and putting out our bins
2. Intermediate – co-production can be a tool of recognition through service user involvement or patient engagement, listening to the views of people
3. Transformative – users of services and professionals are involved on an equal basis in the design and delivery of services. This requires a relocation of power and control.

Co-design and other ways of asking service users for their views or advice are progress, and may build the ground for co-production, but without the crucial element of delivering services. It goes without saying that community projects where citizens organise for themselves are very valuable; however they are not in themselves co-production.

At its most radical co-production, where people and services are changed, goes beyond service user involvement and engagement and involves the transfer of power and responsibility. Conventional methods of involving service users only allow the contribution of some people. Because equality is at its core of co-production everyone must be able to participate. Some of the best examples are from social care for people with learning disabilities and those with dementia.

Two examples of a co-production way of working are time banking and peer support.

**Time banking**

Time banking is a community development tool and works by facilitating the exchange of skills and experience within a community. A time bank uses an alternative currency: time instead of money. For every hour you spend helping someone in the community you are entitled to draw on the time bank for an hour of help in return. Everyone’s services are equal so an hour of computing skills is equivalent to an hour’s dog-walking, helping someone fill in a form or gardening. The time bank is co-ordinated by someone who keeps account of the hours spent and accrued by each member. Organisations and community groups can also be members of a time bank. Local authorities have used time credits to pay people to design and deliver local services. One good example is attached to a GP practice in south London. The Rushey Green Time Bank was started by a local GP as an alternative treatment for patients suffering from depression or isolation. The Return on Investment for Time banks is positive and research has shown that the ‘hardest to reach’ groups get involved.

Time banking uses the assets and resources of the community, builds social networks and does more with less. In Wales the approach has been to facilitate time banking through an agency rather than person to person. Spice Wales supports public organisations to host time
banks where people give time to the organisation. The credits are exchanged for leisure activities or local education classes amongst other opportunities.

**Peer Support**

Another method of equal exchange is peer support or peer mentoring programmes. Trained supporters, who have usually been through the same experience, meet as equals with clients. Other models are those of self-management programmes who use trained volunteers with experience to deliver training and education to clients, as in the national Education Programme for Patients and other programmes, particularly in mental health.  

4. **The Evidence Base - what evidence is there to support a health assets approach?**

“Although there are small scale examples from across the globe of how these approaches to health development have changed people’s lives and increased wellbeing, there is insufficient evidence of changes in health outcomes, whether seen in deficit terms (as mortality and morbidity), or asset terms (as changes in social capital and wellbeing).”

Many of the cases where asset approaches have been used are small and without the resources to properly evaluate their work. As Professor Sir Michael Marmot concluded, the hierarchy of evidence which dominates biomedical research is inappropriate for work focused on the social determinants of health. Shepherd has suggested that part of the challenge for public health is to develop new indicators and ways of evaluating this work including health asset approaches. However, despite the lack of specific evidence on the relatively recent practical application of this approach, there is evidence which relates health assets to health and wellbeing outcomes. Indeed,

“The research evidence for the positive impact of community and individual assets such as resilience, self determination, reciprocity, social networks and social support on health and wellbeing is well known and at least comparable to that of more familiar social determinants of health such as housing, income and the environment.”

**Individual assets in context**

We know that socioeconomic disadvantage is a major factor in people’s life prospects. The question as to why some people who go through periods of adversity nevertheless come through it to lead healthy and fulfilling lives has received considerable attention. The concept of resilience – the ability to ‘bounce back’ from adverse experiences – has been a focus for researchers. Warm and secure attachment with parents, support for aspirations and self-esteem by schools, supportive relationships at home and at work have all been found to be positive factors that encourage resilience. The qualities of human relationships and of public service responses to people with problems are important, but it is social relationships that are most effective in maintaining resilience in the face of adversity.

Mental wellbeing has a profound role in shaping physical health and contributing to life chances, as well as being important to individuals and as a societal measure. We also know
that mental wellbeing is linked to healthy behaviours – the better your mental wellbeing the more likely you are to exercise, not to smoke etc.\textsuperscript{42}.

However, the marked social gradient in both mental illness and levels of mental wellbeing suggests a clear relationship between psychological distress and the material circumstances of people’s lives. Marmot found that negative health outcomes are linked to the stress people experience and the levels of control people have over their lives and this stress and control is socially graded. Mental health is both an outcome of your position in the social hierarchy and a determinant\textsuperscript{43}. (See footnote\textsuperscript{1})

The focus on individual ‘assets’ to offset adversity has made some researchers uneasy. A review carried out for NICE\textsuperscript{44} warned that “the SOC [Sense of Coherence] construct can lend itself to explanations and interventions which are neglectful of the fact that people in poverty often have very limited control over their circumstances.” Lynne Friedli gives a cogent argument for the dangers of focusing on individuals without acknowledging the importance of the larger socio-economic environment\textsuperscript{45}. Psychosocial assets are tied to material advantage and can’t be taken out of context. She argues that status, control and affiliation are universal determinants of wellbeing and that these are the factors that public health should be interested in shoring up.

Social Networks

The evidence around the health benefits of social relationships is robust and clear.

“\textit{Individuals who are socially isolated are between two and five times more likely than those who have strong social ties to die prematurely. Social networks have a larger impact on the risk of mortality than on the risk of developing disease, that is, it is not so much that social networks stop you from getting ill, but that they help you to recover when you do get ill.}”\textsuperscript{46}

The link between social networks and mental health is also well established. National surveys of psychiatric morbidity in adults aged 16-64 years in the UK show that the most significant difference between people with mental health problems and those without is social participation. There is strong evidence that social relationships can also reduce the risk of depression\textsuperscript{47}.

Perhaps the most conclusive is a large international meta-analysis\textsuperscript{48} of data carried out in 2010 which indicates that individuals with adequate social relationships have a 50% greater likelihood of survival compared to those with poor or insufficient social relationships. The analysis concludes that: ‘The quality and quantity of individuals’ social relationships has been linked not only to mental health but also to both morbidity and mortality [and] it is comparable with well established risk factors for mortality” such as smoking, alcohol, body mass index and physical activity. This finding is consistent across other demographic factors such as age, sex and cause of death.

\footnote{1 It should be noted that mental health itself is a value laden term. Consider the characteristics that are chosen as representing health in some of the literature – confidence and self-esteem, for example – and note how culturally driven they are. The concept of mental illness is also contested – one way of seeing it is as a legitimate expression of human despair or distress. As Krishnamurti points out “It is no measure of health to be well adjusted to a profoundly sick society.”}
The authors conclude that social relationship-based interventions represent a major opportunity to enhance not only the quality of life but also survival. Supporting people to use their ‘naturally occurring social relations’ and community-based interventions which include a broad cross-section of the public may be more successful, they suggest, than social support provided by paid staff. Furthermore evidence strongly supports the beneficial effects on mental health and wellbeing of reciprocal relationships across a wide range of interpersonal interaction\(^49\).

**Community Engagement and Co-production**

“Up to 50% of patients fail to adhere to prescribed medication at a cost to the health service of billions of pounds.”\(^50\)

In general, the evidence suggests that empowerment and engagement initiatives can produce positive outcomes for the individuals directly involved, including: increased self-efficacy, increased confidence and self esteem, personal empowerment, improved social networks; a greater sense of community and security and improved access to education leading to increased skills and paid employment. Research also reports significant health benefits for individuals actively involved in community empowerment/engagement initiatives including improvements in physical and mental health, health related behaviour and quality of life\(^51\).

*NICE*\(^52\) has reviewed the evidence on community engagement generally and concluded that approaches that help communities to work as equal partners (co-production), or which delegate some power to them – or provide them with total control – may lead to more positive health outcomes. (They may also improve other aspects of people’s lives, for example, by improving their sense of belonging to a community, empowering them or otherwise improving their sense of wellbeing). This is achieved because these approaches:

- utilise local people’s experiential knowledge to design or improve services, leading to more appropriate, effective, cost-effective and sustainable services
- empower people, through, for example, giving them the chance to co-produce services: participation can increase confidence, self-esteem and self-efficacy (that is, a person’s belief in their own ability to succeed). It can also give them an increased sense of control over decisions affecting their lives
- build more trust in government bodies by improving accountability and democratic renewal
- contribute to developing and sustaining *social capital*
- encourage health-enhancing attitudes and behaviour.

It has been difficult to evaluate the cost-effectiveness of community engagement, assets-based or not, as the benefits and costs are difficult to translate into financial terms and the spending by one organisation may benefit another. However, there are many examples of community development offering good value for money and a return on investment\(^53\).

Some evidence for ‘asset based approaches’ was found by the team from Cardiff carrying out the review for *NICE*\(^54\). Good quality evidence was found on the effectiveness of ‘resource-building’ approaches such as skills training, mentoring programmes and initiatives
aimed at building family strengths. Interventions to build protective factors included more inclusive approaches and skill building programmes in schools and interventions which build social support and social networks.

Most co-production initiatives are small and have not been independently evaluated so the orthodox evidence for improved outcomes for individuals and communities and for increased efficiency is not strong. Despite the difficulties in evaluating co-production in particular there is strong evidence more generally that involving people in the design and planning of services is essential for effectiveness. Research also shows that relationship-based partnerships have the power to influence health outcomes. Instead of the entrenched paternalism of current services, establishing trusting, accountable and long-term relationships facilitates an adult–adult relationship where there is shared responsibility for health outcomes. And an evidence review by Woodall found promising evidence that empowerment, envisaged as a consequence of co-production, improves health and wellbeing.

What we do know is that a sense of belonging and of making a contribution is valuable and that if this is not in place then being left out leads to social death and challenging behaviour. Low cost interventions can make a big difference and in some areas such as mental health, we have limited interventions that we know are effective. We should also perhaps argue from a value base – that the enhanced rights and autonomy that accrue to individuals through co-production, should be reason enough to do it.

Health Inequalities

One of the main justifications being put forward for the use of a health assets approach is to address the stubborn inequalities in health which, it is said, is one of the failures of health policy. Several commentators suggest that it has the potential to address this issue. The mechanism for this seems to be based on ‘the extent to which people can participate and have control over their lives [making] a critical contribution to psychosocial wellbeing and to health’.

However, this position ignores the fact that widening health inequalities have happened against a background of rising material inequalities. In the UK income inequality has risen faster than in any other OECD country since 1975. Friedli argues that proponents of asset approaches within public health have failed to acknowledge this and their “fatal weakness has been the failure to question the balance of power between public services, communities and corporate interests”. If I have understood correctly, and the suggested mechanism is focused on individual psychology then it is possible that inequalities could be aggravated unless activities are truly inclusive. With this in place it is possible that with a focus on strengthening social networks, assets approaches could embrace those currently outside the social mainstream. This could improve mental wellbeing and access to community resources for those most disadvantaged which would have a positive impact on their health. For this to happen initiatives would have to take a whole population approach to a neighbourhood, rather than targeting disadvantaged populations in isolation.
And whilst there is a wealth of data documenting the amount and type of inequities that exist in populations, there is little empirical evidence about the effectiveness of strategies for reducing them\(^64\).

Clearly this is one of the complex and intractable problems mentioned at the beginning of this report. It has been argued that the increase in inequalities in income is destroying social capital and therefore affecting everyone’s health\(^65\). Local interventions, including some health assets approaches, might strengthen this ‘glue’ which holds society together, but may leave the underlying shape of income distribution, and therefore power, untouched.

**Evaluating Health Asset working**

If the measures we use for health status at the moment are based on a biomedical model and the deficit approach and are not appropriate for wider ‘health’ work, how might we develop new ones? The orthodox approach to measuring health is based on epidemiology and Randomised Controlled Trials (RCTs). At present epidemiology provides little help in evaluating the effectiveness of assets and protective factors. The strength and weakness with RCTs is that they work with a simple question of a defined population and a defined intervention. But in complex systems which define health and wellbeing, where many elements interact to produce outcomes, there will be non-linear effects. That is, a large input can have a small effect on the system, whilst a small one may elicit a big impact. In these cases we need to know not just ‘what works’ but also know more about how and why. Alternative qualitative evaluation methods more suited to this kind of knowledge are *Action Research*, Appreciative Inquiry, Action Learning Sets, Participatory Research, reflective practice and stories, some of which are already well developed and widely used tools.

Morgan and Ziglio\(^66\) argue that redressing the balance in public health might mean taking an assets approach to the evidence base. This could involve a systematic method of gathering evidence about health assets and could open up fruitful areas of research. Epidemiology could be applied to understanding patterns of health in the same way it currently looks at patterns of disease. New indicators more appropriate to health assets work are starting to be developed. For a number of years people have been working on indicators of wellbeing\(^67\) and others to measure social capital or community cohesion\(^68\).

Results Based Accountability (RBA)\(^69\) is a performance measure which has become popular over recent years and is being used in many organisations across Wales. Assets approaches fit well with RBA, particularly Appreciative Inquiry. In this way of accounting all work which contributes to the overall aim (for example, the health and wellbeing of the population) is valued. Because how you get there is not so important in RBA, asset based approaches can sit alongside more conventional services and programmes. Positive indicators for health assets could easily be incorporated.

Jane Foot points out that the progress we make on developing appropriate evaluation measures and indicators for health assets and approaches will help us answer the two key questions for work on health improvement and inequalities – Does it work? And is it worth investing in? \(^70\)
5. **Health Assets in Practice**

“Life is not a problem to be solved.”

*John McKnight, ‘The Abundant Community’*

A Health Assets Approach to Public Health

In 2012, Public Health Wales commissioned Dr Michael Shepherd to review the research on health inequities and community cohesion and to explore how an assets approach might benefit public health. He was clear that a paradigm shift, as we have previously discussed, would be needed:

*The assets model of health begins with a reconceptualisation of health from a focus on disease and deficits to a focus on wellbeing and assets or resources. This salutogenic approach moves health promotion away from traditional public health, toward broader conceptions of community, sustainability and social action.*

The Ottawa Charter for health promotion identifies three basic strategies: advocacy to create the essential conditions for health; enabling people to achieve their full health potential; and mediating between the different interests in society in the pursuit of health. Within the Charter, five priority areas for action are defined:

- Building healthy public policy
- Creating supportive environments for health
- Strengthening community action for health
- Developing personal skills, and
- Re-orienting health services

These strategies focus not on illness, but on the capacity of individuals and communities to maintain health by employing the resources they are able to access. Despite this, current public health policy and practice is wedded to a deficits approach and, in Morgan and Ziglio’s description ‘is focused on the failure of communities and individuals to avoid illness’. A biomedical model of risk and measures of health which rely on negative outcomes of morbidity and mortality do not help us think about the factors that promote wellness. Taking a view of health as a ‘resource for everyday life’ (and not an end in itself) would require a paradigmatic shift away from the current model. What would it be like for public health to redress the balance by promoting health and wellness through work on health assets?

Whilst we know that “traditional epidemiological risk factor approaches to health development such as smoking cessation, healthy eating, physical activity are insufficient on their own to ensure the health and wellbeing of a population” nevertheless public health has generally struggled to move the debate on. Some have argued for a more radical reappraisal of public health, a new paradigm which is fit for the 21st Century. They argue that at present public health is overly reliant on reductionist approaches – single topic issues
– whereas the complex overlapping problems we face require us to develop a paradigm which includes qualitative methods, systems, ecology, narratives, dialogue and pattern recognition. Assets based approaches would integrate well.

So, how can public health teams and their partners apply assets based thinking and approaches to their work?
Firstly health assets thinking provides us with an alternative strategy to our usual deficits approach. There is always the possibility of asking a different, appreciative question or seeing a ‘problem’ from another, assets based perspective. Then Whiting draws out three key aspects in her analysis of Morgan and Ziglio’s model for an asset based approach to public health. These would enable policy makers or practitioners to consider health from a positive angle.

1. Embrace salutogenesis – identify factors that promote health at an individual, community and institutional level
2. Asset mapping – equip health promoters with an understanding of how best to create conditions required to maximise the potential for health
3. Asset indicators – to assist in the evaluation of health promotion interventions.

‘An asset-based approach to public health, then, acknowledges the massive interconnectivity and complexity inherent in systems like neighbourhoods and communities. It conceives of ‘good health’ as emerging from dynamic networks of (semi-) independent sense-making actors, replete with feedback loops, where the actions of one set of actors can set the context for others in loops of infinite regress that are sensitive to historical contingencies. When conceived of in this way, the evaluative task is to try to understand the local assets (through ‘asset mapping’) and to figure out the dynamics that link these (individual and collective) assets to change.’


On this last point Dr Michael Shepherd argued that in the evaluation of outcomes the practice of public health needs to change to accurately reflect the full concept of health promoted in the assets model. He further argued that we should use language which emphasises the strengths and resources of a community alongside the more orthodox measures of morbidity and mortality. He concluded that taking this different approach could help address inequities in health and improve the health of the population of Wales. His caveat was that there had to be reiteration of the importance of the social determinants of
health and their role in inequalities. He also warned that high level commitment is needed if it is to be successful.

Experience so far suggests that it is more effective, and manageable, to work locally and at a small scale. The knowledge gained and networks built through solutions developed locally are place-contingent. We should resist any move to ‘roll-out’ or ‘scale up’.

Some Examples of Asset Based Initiatives in Practice

Over the past few years many organisations, small and large, have started to develop asset based approaches. Examples of organisations bringing co-production into services, particularly social care, make up the majority of these. They range from transforming mental health services in Australia, to services supporting families in Cardiff and creating better social lives for people with learning disabilities in Swansea. The common theme of these initiatives is in a change to the nature of the questions asked: From ‘What’s wrong?’ to ‘How would you like your life to be?’ ‘What would you have to do to achieve this?’ and ‘How can we support you?’.

Examples of genuine asset approaches in health and public health are less easy to find. The Northwest of England, though, has been particularly active in developing them. A range of organisations, including councils and health bodies, have pioneered a range of appreciative approaches to strategic planning, to service redesign, to neighbourhood renewal and to problem solving. The potential of time banks associated with health services has been explored, social prescribing is becoming more common, and peer health trainers and champions could also be placed under the banner of assets approaches to health and wellbeing.

In the Hywel Dda area, although the language of health assets and co-production is not widely used yet, there will be organisations taking an assets approach, or which could reorient themselves more fully along these lines. And there will always be individuals and organisations who naturally work with people’s strengths. During the writing of this report some of these came to my attention: there will be others I have missed. Although only one of the following examples describes itself in ‘assets language’, they all show characteristics of an assets approach to health and wellbeing.

Communities Together, Fishguard and Goodwick

In the twin communities of Fishguard and Goodwick in north Pembrokeshire, Alcohol Concern has employed a community worker who is taking an Assets Based Community Development approach to explore attitudes to alcohol in the area. The project is at the beginning stages but its alternative approach is already obvious. The worker is initiating conversations with people in the town with questions like ‘What’s good here?’ and ‘What would improve it?’ This often naturally raised topics linked to alcohol, and helps to encourage conversations about the good and bad aspects of alcohol use in our communities. Apart from stimulating an open discussion about drinking, the worker has no ‘message’. The hope is that this discussion will encourage and empower local people to identify specific alcohol-related issues and needs, and develop their own bespoke initiatives to address them, with the assumption that they are best placed to identify and implement
local solutions to local problems. The project will not aim to discourage alcohol use as such, but to promote a healthy relationship with alcohol for individuals and for the community as a whole. Finding the ‘community connectors’ – those people who know people, the networkers – is one of the first steps as they can then help to start linking people up. The project has the benefit of evaluation built in from the outset including a baseline survey about behaviour and attitudes around alcohol.

Ceredigion County Council – Mapping activities for older people

The Ceredigion Strategy for Older People Co-ordinator has carried out an audit of activities for older people, which are organised by the community but including some provision by third sector organisations. The multi-agency ‘Caring Communities’ Working Group is using the information to identify ‘best practice’ communities which show a high degree of engagement and activity and to develop and publicise best practice case studies. Through this they hope to inspire others into taking steps to do the same. For example, in one community two retired medics have offered a ‘healthy Wednesday’ slot where people could ask advice and take part in healthy activities.

This initiative would benefit from an Assets Based Community Development approach. They have already identified many of the community connectors. An assets mapping tool could be used to initiate discussions with older people in this community, to connect people up and discover shared interests and promote exchange. Often these activities are not sustainable because they rely on the same people volunteering. They could bring these people together and encourage them to start asking people about their gifts and encouraging exchange and mutual support. There would be a good chance that those communities would then develop to be able to ‘do for themselves’ – which is the ultimate the aim of this small piece of work.

Tywi Creations – Llandovery/Llandeilo, Carmarthenshire

In Carmarthenshire individuals with lived experience of mental distress had the idea of building on the good experiences they had had with arts workshops to provide something more permanent and sustainable. They approached the Myddfai Centre and West Wales Action for Mental Health and have brought in other organisations when they identified that their skills could make a contribution. The network now includes Towy Valley Community Mental Health Team, Myddfai Centre, Artscare, Llandovery YMCA, individuals from the area and Links. Tywi Creations will offer arts, crafts and other supported learning opportunities and through a social enterprise model sell artwork to Myddfai Centre and other local galleries. It is early days in the development of this partnership but an ‘Awards for All Wales’ application has been successful with a grant of £5000. Although they have not labelled this as co-production or an assets approach, the key elements are there. It is citizen-led, a genuinely equal partnership between professionals and people who use services in a local neighbourhood, clearly values their assets, and is inclusive – everyone has access to the resource which can help them flourish.
A winner at the NHS Wales Awards 2013, this small project is an example of co-production which verges on the transformative. A team from HDHB including patient experience and Speech and Language Therapy Service, involved from the start a group of adults with learning disabilities, Siarad Iechyd/Talking Health members, the Community Health Council, outpatients user group, hospital staff and hospital estates department. They did this, not through consultation or survey, but by face to face relationships with people and service users had the final say. They discovered that by challenging their assumptions service users had innovative solutions to the problem of people getting lost and becoming increasingly anxious. During this small project the relationships between professionals and citizens were changed. Friendships were made and power was equalised. They now have an ‘asset’ to take forward – a group of well-disposed people, with experience to redesign and improve another aspect of the service or environment.

6. Opportunities, Risks and Challenges

Why adopt a health assets approach?

Asset based working has a strong resonance with health promotion principles and has some obvious strengths. It has the potential to address some of the most difficult problems in public health and in health and social care services, including health inequalities, from a different angle with the possibility of success, or at least a better understanding. But there is an array of obstacles and difficulties ahead. At the sharp end especially, it is not an easy option.

Health assets approaches have a set of values and principles which can provide a helpful framework for us to assess and plan initiatives for health and wellbeing. As asset based approaches facilitate the identification of many factors that protect and promote health, it could broaden our perspective and open up new possibilities for action. Furthermore, because assets approaches are open-ended the need to get across ‘messages’ about risks to health is redundant. We simply trust that, based on strong evidence, a way of working with a clear set of principles will result in an improvement in health. Asset approaches inherently embody health promotion by enhancing mental health and wellbeing, empowering people and building social networks.

Assets approaches build interdependencies, social networks and reciprocal relationships which are known to improve health and wellbeing. Because assets approaches are inclusive – facilitating the hearing and valuing of others – this may strengthen social networks and act against inequality. They help people use their talents and encourage them to create their own health in a way that makes most sense to them. Finally, health assets approaches are realistic, identifying what is already available.

The most serious problem the health service faces is the increasing number of people living with ‘chronic illnesses’ and helping people to stay well with them. Might a more equal relationship between health professionals and patients deliver this?
If individuals are to take more responsibility for their own health co-production could provide more scope to improve health from the client’s perspective rather than according to measures of morbidity and mortality. This is where peer support systems and self-management programmes such as the Education Programme for Patients (previously the Expert Patient Programme) can show us the way forward. Public services have struggled to find a way to deliver person-centred services for a number of years. Is this a model by which they could actually be person-centred? It could unleash the creativity, energy and resources of individuals and communities to provide sustainable public services.

For organisations the techniques to promote asset working such as Appreciative Inquiry and Asset Mapping provide a tool to change the current situation, whatever that is, by taking people with you rather than imposing decisions from the top.

**Risks and Challenges**

In almost all the literature in health assets approaches there is little discussion of the challenges and risks of taking an asset based approach, yet they should not be lightly dismissed. The first question is – how can we be sure it is not a new fad? Whenever a ‘new’ idea gains popularity, old stuff gets rebranded with the new terms. The Welsh Minister for Health and Social Services himself warned against the use of ‘deodorant words’ which are devalued as a result. We need to be aware of the mislabelling of work which does not accord with asset working principles and of attempts to pass off information that has been ‘spun’ to put it in a better light, as new. Defining terms carefully may be the essential first step.

There is a danger that a cynical view could prevail. Any attempt to involve people in the delivery of services, for example, may be seen as public services stepping back. People may see it as an abnegation of responsibility by services. The values and potential outcomes will need to be clearly expressed.

Co-production, in particular, requires the commitment and expertise of those working with service users and patients. Professionals, and this is especially true in health services, hold a set of beliefs that inform their understanding of their role in their work. This may include an adherence to an expert model, a reductionist or medical model of health and a sense of importance and satisfaction from helping people. Many health and social care professionals have spent years building their expertise and may find it difficult to let go of their ‘expert’ position to one which is ‘alongside’. How can people (and I mean both clients and staff) brought up within this system begin to work together as equals? Any meaningful answer to this question requires a process of growth. Clients themselves may well need support to become more active partners.

Almost intrinsic to becoming a professional is the creation of a professional role so as to prevent burn-out from constantly giving out. Reciprocal relationships are healthier for both sides, but removing professional distance means that you are involved in the relationship in a different way with the highs and lows that this brings. There would have to be investment in time and money for training to provide front line staff and public health teams with the new skills they need. Working in a different way might be resisted.
Furthermore, frontline workers need to be empowered as much as their clients. A lack of leadership could stymie the good intentions of people lower down the hierarchy. Shepherd notes ‘the deeply entrenched paternalism in delivery of services predominant within the public sector represents a major barrier’\(^87\).

One of the difficulties of the asset based approach is that it is “community led, long term, open ended and has less certain, measurable or predictable outcomes, which are likely to take time to emerge”\(^88\). And the investment in this work may not come back to the organisation which paid up front.

**Opportunities for Public Health**

The recent and increasing popularity of assets approaches means that there is fertile ground for starting to develop this work in public health. On the other hand it would be wise to think through the implications. In particular, a firm set of principles will enable any proposed activity to be evaluated for its health asset credentials before starting.

The following are some ideas as to how Hywel Dda Public Health Team might incorporate health assets working and influence other local health improvement activity.

Firstly, in the three key areas suggested in section 5 – embracing salutogenesis, health asset mapping and health asset indicators:

**Embracing Salutogenesis**

- Recognise the strong evidence base on the broad range of factors that affect health and widen our health improvement activities to include those that promote reciprocal relationships and social networks
- Practise our ability to ‘switch’ from ‘deficit thinking’ to ‘assets thinking’ in a wide range of situations and apply that thinking to our work
- Look at the existing data from a positive angle. Not simply ‘spinning’ it by stating that 77% of people don’t smoke, but a genuine enquiry into the stories behind that success which would help us learn from it.

**Health Asset Mapping**

- Include health assets alongside needs assessments\(^89\)
- In Appreciative Inquiry mode we might first look for more of what is already happening locally which has the characteristics of an assets approach to health and wellbeing. By investigating whether and how this is working may help us to start identifying activities that promote health in our local communities
- The commitment to even a small health assets mapping exercise would be difficult for the Public Health Team because of the lack of people working at a community level. However, the team could promote this method of working and skill up people in other
organisations to do it.

Health asset Indicators

- Review how interventions are currently evaluated
- Develop or adopt new asset indicators to assist in the evaluation of health improvement activities
- The WARM (Wellbeing and Resilience Measure) could be used as a positive indicator of the health and wellbeing of the local population.

Influencing Others

Hywel Dda University Health Board has a new organisational framework based on eight Population Health Groups. A member of the Public Health Team sits on each one. Taking an assets approach might mean:

- Looking at the group itself and the skills, talents and gifts of its members
- Ask ‘What is working well?’ in the services covered by the group
- Consider how to link in better with the existing ‘Education Programme for Patients’ or peer support groups, or explore new ways to encourage users of the service to associate with each other
- Consider social prescribing opportunities into existing community networks
- If co-production seems a step too far, then how about co-design where patients and their families are fully involved in designing a service?

The ‘Third Sector’ is in a good position to take these ideas forward as they are further developed in terms of service user involvement and engagement. The Public Health Team and Hywel Dda University Health Board could identify where asset based working is happening and potentially provide financial support, or when commissioning services could stipulate co-production methods in the contract.

And finally, Appreciative Inquiry thinking can be used in almost any situation...

“An Appreciative Eye gives us the capacity in the world around us, in our colleagues and (in our teaching and learning), and in our organization to see the true and the good, the better and the possible.”

David Cooperrider, Ph.D., Case Western Reserve University
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32 SCIE (2013), Co-production in Social Care: what it is and how to do it Guide 51, SCIE, London
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40 Bartley, M. (2012). What we know about resilience in Foot, J. What Makes us Healthy?
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54 Harrop, E. Et al (no date). Resilience, Coping and Salutogenic Approaches to Maintaining and Generating Health. Cardiff Institute of Society Health and Ethics at Cardiff University, A Report for NICE,
55 Needham, C. Presentation to the conference Co-production and Mental Wellbeing, All Wales Mental Health promotion Network, 6/11/2014


For example the ONS is measuring subjective wellbeing and the Glasgow Hospital Mental Health & Wellbeing scale is well established

See for example Buckner’s Neighbourhood Cohesion Scale and the ONS Guide to Social Capital


For more information about the Communities Together, Fishguard and Goodwick see www.alcoholconcern.org.uk/pembs or contact the Project Manager Marc Mordey. Tel : 07474 006269; e-mail: mmordey@alcoholconcern.org.uk or write to him at Alcohol Concern, PO Box 22, Fishguard, SA65 0AF

For more information on the Mapping Activities for Older people initiative contact Gweneira Raw-Rees email: Gweneira.raw-rees@ceredigion.gov.uk or tel. 01545 574019

For more information about Tywi Creations contact Myddfai at www.myddfai.org

For more information about this project contact the Hywel Dda University Health Board Public and Patient Engagement Team


Mark Drakeford ‘Coproducing Mental Wellbeing conference’ 6/11/13, All Wales Mental Health Promotion Network


Glossary

**Action Research** – a reflective process of progressive problem solving in a community of practice.

**Asset approach** – or asset-based approach or asset-based working. I have used these somewhat interchangeably to mean any method or tool that values resources and assets that can be used to build health and wellbeing.

**Asset Mapping** – a participative process of identifying collective resources – talents, skills, knowledge, networks and physical resources – of a community.

**Co-design** – asking the advice of users in the redesign of services

**Co-production** – the process whereby clients or service users work alongside professionals as equal partners to create and deliver services

**Community Engagement** – Community engagement refers to the process of getting communities involved in decisions that affect them. This includes the planning, development and management of services, as well as activities which aim to improve health or reduce health inequalities

**Deficit Model or Deficit Approach** – a view of the world that focuses on needs, lack and problems.

**General Resistance Resources** (GRR) – a key concept in *Salutogenesis* these resources may be internal or they may lie in the social environment, and could be material or non-material in nature.

**Health** – According to the Ottawa Charter, health is a resource for everyday life rather than the objective of living. My own preferred definition of health is as the ‘foundations for achievement’ – a set of basic building blocks which define your health status and are linked to your ability to achieve your potential. Both recognise that everyone has health and that there is a wide range of routes to increase it.

**Health assets** – Any factor that supports individuals, communities and populations to maintain and sustain health and wellbeing.

**Health Inequalities** – the ‘differences in health status or in the distribution of health determinants between different population groups’ (WHO). For example rich people live longer than poor people and those in a lower social class.

**Hierarchy of Evidence** – a means of judging research evidence presented in the medical literature and the foundation of evidence-based medicine.

**NICE (National Institute for Health and Care Excellence)** – provides evidence based guidance and advice for health, public health and social care practitioners
Reciprocity – the practice of exchanging things with others for mutual benefit.

Resilience – the ‘successful’ adaptation to life tasks in the face of social disadvantage or highly adverse conditions.

Sense of Coherence (SOC) – a term introduced by Anton Antonovsky in his theory of Salutogenesis, SOC has three components – comprehensibility, manageability and meaningfulness.

Social Capital – although definitions vary there is a broad consensus that it includes informal and formal networks, group membership, reciprocity, trust and community participation

Social Prescribing – Social Prescribing creates a formal means of enabling primary care services to refer patients with social, emotional or practical needs to a variety of holistic, local non-clinical services
Appendix 1 – Methodology for the report

Objectives:

- Explain the concept of health assets
- Explain the assets approach to health improvement
- Describe the tools used in the assets approach
- Describe some examples of where a health assets approach is working well
- Summarise the evidence for taking an assets approach
- Make recommendations for how Hywel Dda Public Health Team could integrate an assets approach into their work.

A description of the research process

The Library and Knowledge Management Service of Public Health Wales provided a reading list based on their literature search of ‘health assets’. I discovered that Public Health Wales had commissioned an evidence review on health assets which was published in 2012. Given that these two pieces of work had already been carried out recently there was no need to repeat this through a new literature search. Instead I used the LKMS list as core reading and followed up references cited to find further sources – papers, reports and websites. For local information I followed up leads and conducted informal interviews with people who are using asset approaches.

I have attended the following conferences/events

- ‘Co-producing Mental Wellbeing’ – Mental Health Promotion Network, 6th November 2013
- ‘Co-production Health & Social Care event’ – Aneurin Bevan University Health Board/Public Health Wales, 12th November 2013
- Seminar on Asset based approaches to health in Wales – Public Health Wales, 29th November 2013
- Webinar on Co-production, Hywel Dda University Health Board, 7th March 2014

The case studies and examples in this report have been chosen to illustrate a particular aspect of assets approaches. Due to the limited time available I have not attempted to systematically uncover all the organisations taking an assets approach in Hywel Dda area. Many organisations, particularly in the Third Sector, unconsciously incorporate aspects of co-production in their work. In this report I wanted to look for where people were doing something different and with some awareness.
Appendix 2

Further Reading

For those who want to know more the following list of reports and papers will be helpful:


**Salutogenesis** – Anton Antonovsky’s original paper from 1996 ‘The Salutogenic Model: a theory to guide health promotion’ in *Health Promotion International*, vol 11 issue 1, is a good read or Dr Shepherd’s report has a section.


**Co-production** – ‘The Challenge of Co-production: how equal partnerships between professionals and the public are crucial to improving public services’, David Boyle, New Economics Foundation 2009
